MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
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ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Assessing payment adequacy and
updating Medicare payments for hospitals --
Jesse Kerns, Jack Ashby, Chantal Worzala

AFTERNOON SESSION [1:22 p.m.]

MR. HACKBARTH: The next item on our agenda is a continuation of assessing payment adequacy. The focus of our next session is hospitals, both inpatient and outpatient. Jesse, you're going to do the intro on this; is that right?

MR. KERNS: I'll be discussing the first step in our updating process for hospital services, assessing the adequacy of current payments. And then Jack and Chantal will address the second step, allowing for cost increases in the coming year, separating for inpatient and outpatient services.

The first step in this process is to determine whether the hospital cost base is appropriate. The second step is to assess the relationship of Medicare payments relative to appropriate costs. This will allow is to do two things, first assess whether the overall level of payments to hospitals is adequate and second, to then consider the distribution of payments among hospitals. Our approach is to consider Medicare payments to the whole hospital for all hospital services purchased by Medicare.

In addressing the appropriateness of the cost base, we first considered the long term trends that established the hospital cost base in the 1990s. We know that cost growth was modest in the '90s. The biggest reason for this was large declines in Medicare length of stay. For three years in the mid-1990s, cost per case growth was actually negative.

Other factors that kept cost growth down were revenue pressure from private payers and slow wage growth for hospital workers. Based on these factors we concluded that the hospital cost base established in the 1990s was appropriate.

In recent years, we observed that hospital cost growth has increased, especially in 2001. We attribute this to smaller declines in length of stay as well as increased hospital wage growth due to a tighter labor market as well as a nursing shortage. Because of these factors, the recent higher cost growth for hospitals does not appear excessive. This leads us to conclude the current hospital cost base is appropriate.

So we now turn our attention to the relationship between payments and cost. First, we'll consider broad indicators of payment adequacy for hospitals. This includes what investors think about the hospital market, hospital volume, closures and beneficiary access to care. We'll then review other payers payments to hospitals and the hospital total margin. After those subjects, we'll look at Medicare payments and Medicare costs. For this we consider the inpatient margin and the overall Medicare margin.

We'll look at each of these measures in several ways. For 1999 and projected to 2002 with and without DSH and IME payments above our estimate of Medicare's share of the added cost of teaching.

So first, what do investors think about the hospital market? Non-profit hospitals typically raise capital by issuing municipal bonds. There has been a lot of focus in recent years on the relatively large number of hospital rating downgrades, but we feel this has overstated the actual picture.

Despite these downgrades, over 90 percent of rated hospitals and health systems are rated investment grade right now. We note, though, that some hospitals are not rated and there could be some selection bias among hospitals.

One last point on the bond ratings, investment houses report that many downgrades in 2001 were due to increased borrowing by hospitals to fund capital projects, unlike earlier years when poor financial performance drove the downgrades.

Meanwhile, on for-profit hospitals, the value of the for-profit hospital stocks, capital-weighted, increased over 170 percent from 1999 to 2001, while the S&P Index fell 19 percent. It does appear that investors also have a favorable view of for-profit hospitals.

Now we'll consider some macro level indicators of hospital financial performance, volume, entry and exit, and beneficiary access to care. Total volume from all payers has increased, especially in recent years, in terms of total admissions, total days, and outpatient visits. There was a net loss of 340 hospitals from 1990 to 1999, about 6.5 percent of all hospitals. It included 440 closures, of which about 40 percent were rural, and 100 openings or re-openings.

The OIG studied these closings and determined that closed hospitals were small, had low volume, and these closures did not affect Medicare beneficiary access to care. We also note that in some rural areas, access has been created by the critical access hospital program opening or re-opening hospitals in some communities. Despite these closures, it appears there's still enough hospitals and there is excess capacity in the market. Average occupancy in 1999 was 54 percent.

Next we consider what happened with other payers. Medicare, Medicaid and private payers constitute about 90 percent of payments for hospital services. Last year, when we discussed these analyses, we noted that in 1998 and 1999 both the Medicare and private payer payment-to-cost ratio fell, breaking a long-standing inverse relationship that came to be known as cost shifting.

In 2000, however, the private payer payment-to-cost ratio increased slightly, about 0.2 of a percent. This is more pronounced for urban hospitals, where it increased a full percentage point, indicating that urban hospitals have begun to negotiate better payments from managed care. At the same time, the private payer payment-to-cost ratio for rural hospitals fell 2 percentage points.

Now we'll consider the total margin, which includes all revenues and costs to hospitals, including operating and non-operating revenue. The margin for 1999 is a bit of an improvement from the 2.7 percent estimate we presented to you last year. This resulted from adding in data for hospitals with late reporting periods, giving an early indication that 2000 would be a better year. About 37 percent of hospitals had negative total margins in 1999.

While we do not have Medicare cost report data to determine hospitals total margins beyond 1999, we do have a quarterly survey of hospitals that provides a glimpse of hospital financial performance in both 2000 and 2001.

MR. DEBUSK: One point there. It shows 3.6 and you said 2.7. You told us 5.4 last year.

MR. KERNS: That was our preliminary estimate for 2000 based on some quarters of the NHIS. The margin for 1999 from the cost reports was 2.7. And this is good because we're going to update you on the NHIS numbers, for 2000 and 2001. Here they are.

Along with CMS, we fund a quarterly survey of about 500 hospitals. It's weighted to create a representative national sample. In 2000, the full year showed a 4.7 percent margin. And through the first three quarters of 2001, we see a total margin of 4.5 percent.

Because hospital total margins are typically lower in the last quarter of the fiscal year compared with the annual margin, this margin is probably overstated for 2001. I seasonally adjusted the margin and it corresponds to about 4.0 percent.

DR. ROWE: Jesse, this is all payers and all services?

MR. KERNS: Yes, sir.

DR. ROWE: Inpatient, outpatient, everybody?

MR. KERNS: Yes, private, public, this is the total margin, including non-operating revenue. So these findings suggest that the recent poor financial performance of hospitals -- yes, sir?

MR. MULLER: All costs, Jesse?

MR. KERNS: Yes, sir

MR. MULLER: Not just Medicare?

MR. KERNS: No, sir. This is all costs, all sources of revenue, total margin.

So this does suggest that the poor financial performance had perhaps reached its low point in 1999. On balance, the broad indicators of payment adequacy that we just reviewed do not appear to provide evidence of inadequate revenues to hospitals.

So having established this, we now turn our attention to Medicare.

This chart shows margins for each service component and the overall Medicare margin for 1996 through 1999. As in previous years, inpatient payments kept the overall margin positive in 1999, despite negative margins for all of the components. The overall Medicare margin did fall significantly from 1997 to 1999. However, when we discuss payment adequacy, the Commission should consider the absolute level of payments in the system relative to the appropriate cost base, not the change in margin from earlier years.

Now we're going to look at inpatient and the overall margin projected out to 2002. In this chart, we present the inpatient margin for 2002 in two ways: with all payments and excluding DSH payments and the portion of IME payments that are above Medicare's share of teaching costs. MedPAC has determined that current IME payments to hospitals are about twice the level of Medicare's share of the added costs of teaching.

The margin with DSH and IME payments is a measure of the total dollars in the payment system. The other gives us an indication of how core Medicare payments relate to the cost of treating Medicare patients. In projecting margins for 2002, we reflect the effects of a payment policy change that will actually occur in 2003. That is the reduction in the IME adjustment from 6.5 to 5.5 percent. We include this payment change to provide a more complete picture of how hospitals will fare in 2003.

We estimate that the inpatient margin in '02, after accounting for these reduced payments, will be 10.8 percent. By next month it will probably be higher by about 0.1 of a point. We have not yet been able to remove about 200 of the 500 hospitals that have converted to critical access hospital status in the last two years. Without DSH and above cost IME payments, the inpatient margin in 2002 would be 3.1 percent.

The most interesting point to note on this graph, though, is the margin for other urban and rural hospitals in 2002 without DSH and some of the IME payments. Most observers believe that rural hospitals were the worst off, but we can see that the level of their core Medicare payments, they have essentially the same margin as hospitals in other urban areas. But the margin for large urban hospitals remains substantially higher.

This next slide shows the overall Medicare margin for 1999 and 2002. We estimate the overall Medicare margin in 2002 will be 3.8 percent. But it will be quite a bit different depending on where a given hospital is located. There is a nine percentage point difference between the margin for large urban hospitals and rural hospitals. This is narrowed from the 11 point gap in 1999 but still substantial.

We estimate that about 45 percent of hospitals in 2002 will have a negative overall Medicare margin. But this figure, as well, will be marginally lower because of the continued rapid growth of the CAH program and also because increased DSH payments to rural hospitals under BIPA will help a class of hospitals with much lower Medicare margins.

When we net out DSH and the above cost IME payments, the overall margin at the national level falls to negative 2.2 percent. A gap of almost four percentage points remains between large urban and all other hospitals. On this measure, rural hospitals are the worst off by about 0.6 percent.

I remind you that the margins net of above cost IME and DSH are not the margin hospitals actually yield from Medicare. Billions of dollars are paid every year from the Medicare trust fund for both DSH and IME, and the Medicare margin, including these payments, is the appropriate measure of Medicare payment adequacy. It represents the amount of money in the system, which is what we set out to assess. However, these payments do lead directly to substantial disparity among hospitals and it could be characterized as an inequity.

Which brings us to the end of my presentation on payment adequacy, except for one last step, and that is to determine whether the amount of money in the system for Medicare payments to hospitals is about right.

MS. BURKE: Can I ask a question?

MR. HACKBARTH: Why don't you finish the sentence that you're on.

MR. KERNS: It just means that the Commission has to come to one of three conclusions, but implicit in this decision is the appropriate range of payment adequacy. You may not feel comfortable with delineating the range clearly. I tried to show this on the picture, the edges of each band might be gray and fold together.

Our best estimate of the overall margin, as I said, is 3.8 percent. If this is within the band of payment adequacy, we would not make any adjustments based alone on payment adequacy. But if, for example, the entire range of payment adequacy falls lower than 3.8 percent, say 0 percent to 2 percent or 0 percent to 3 percent, then you'd want to conclude that payments are too high and implement a negative adjustment. If on the other hand, the range of payment adequacy is entirely above 3.8 percent, say 5 percent to 8 percent, you'd want to conclude that payments are too low and implement a positive adjustment. For the lowest edge of payment adequacy to be above four seems unlikely, but it is one of the choices available to you.

Regardless of what you conclude, you can also make distributional changes and implement them through the update. Jack will discuss the possible options on this subject next. For now, you just need to decide whether payments as a whole in 2002 are adequate.

MR. HACKBARTH: Murray, how is it most efficient for us to proceed? Should we pause now and discuss the material on payment adequacy?

DR. ROSS: Yes. If I can just change one verb there from decide to discuss payment adequacy, and you don't need to obviously not draw any final conclusions today. But to give us a sense of where you're coming out, to guide the update discussion that's going to follow with Jack and Chantal, and for next month.

MS. BURKE: Mine was just a question of clarification. You referenced gross inequities as a result of the IME. I wondered what you were referring to, inequitable to whom?

MR. KERNS: If you look at major teaching hospitals or hospitals in large urban areas, and because it's revenue weighted that does tend to represent mostly major teaching hospitals. You have very high overall Medicare margins. And in rural areas, and other urban areas, when you net out the IME and DSH, they're quite a bit lower. We've already established that through the IME adjustment we're paying about twice the Medicare share of the cost of teaching.

The first question is as a whole 4 percent, is that adequate? But then the second would be in the distribution you have a nine point gap between one class of hospitals, large urban, and other hospitals, rural.

MS. BURKE: Both of whom have the same level of teaching that occur in them?

MR. KERNS: Not in the least. Large urban hospitals have much more of the teaching and most of the IME adjustment.

MS. BURKE: So I was wondering the reference to the term inequitable. If in fact most of the teaching occurs in those institutions, what is inequitable about them getting a larger percentage of the teaching funds?

MR. KERNS: I did say it's definitely a disparity and it could be characterized as an inequity.

DR. WAKEFIELD: But it's a subsidy piece that's inequitable. It's not the costs associated with teaching, it's the additional subsidy.

MR. KERNS: It's the subsidy above and beyond the cost of teaching.

DR. WAKEFIELD: Which is a very significant --

MR. KERNS: Twice.

DR. WAKEFIELD: Yes, so there is a big disparity I'd say, if you look just at the subsidy that goes into, through IME and the teaching hospitals, for which there is no equivalent in rural hospitals, for example.

MR. KERNS: So you would characterize it as an inequity.

DR. WAKEFIELD: Yes, I would.

MS. BURKE: I might argue that point.

DR. ROWE: I wasn't going to comment on that point, but I guess my view of it is that you may reference that payment as twice what MedPAC has calculated it to be, and I don't know about whether the Commission has decided this, but I think Joe Newhouse decided that those payments were really for patient care costs, not for teaching anyway. So that's probably not...

DR. NEWHOUSE: But not the subsidy part.

DR. ROWE: No. And we had a separate discussion that there was a subsidy.

But I wanted to ask two questions, Jesse. One is I wanted to reconcile or relate page nine to page 12 here, because we go from trend in total hospital margin to overall Medicare margin. You broke down the overall Medicare margins by urban, large and other, and rural. But you didn't break down the trend in total hospital margin.

I just wondered how that would look. The rurals, which appear to be disadvantaged relative to the large urbans, as you pointed out, with respect to either all payments or all payments without the DSH and IME with respect to overall Medicare. We have here had discussions in the past about the fact that Medicare doesn't negotiate with these rurals, but all the other payers do. And therefore, there's often a compensatory payment in that negotiation because they're sole community hospitals, they need to be in the network, et cetera, et cetera. That's not to say marketplace always.

So it would be interesting to have that comparison.

MR. KERNS: I'd be happy to walk you through a brief piece on that. You may recall from last year when we were doing our rural study I did break out margins by urban and rural. Rural total margins do tend to be a good bit higher and they never really had the fall off in '97, '98 and '99 that you saw for urban hospitals. They are, best estimate in my memory, around 5 percent still. And they never really did fall off.

And what you touched on, the private payer payment-to-cost ratio, also expresses that. Rural hospitals have been able to yield well over 130 percent of costs on their private payer payments for the last 10, 11 years.

DR. ROWE: So my point being that as we get to the assessment of the adequacy, inadequacy or neutrality of the payments, if we get to a subset of hospitals that might be triggered by page 12, I just want us to understand the overall margin.

The second point relates to page 13 and the 3.8 percent and the interesting comments that you made and that Jack referenced and that is in the material with respect to access to capital. I'd say a few things.

One, based on my experience, there is a selection bias here. You're right in saying that if you want to float bonds you have to get a rating. But the fact is that you go and you find out what your rating will be. And if it is not good enough to support floating the bonds, then you don't get the rating. Because it doesn't do you any good to have a bad rating, if you don't need a rating at all. And therefore, all of the hospitals that would not get ratings that were adequate don't get rated.

Secondly, is investment grade rating, which you referenced Standard & Poors, so that's BBB, I think. That is often not adequate to float bonds. In many states the authorities, which are established to underwrite the issuance of bonds for not-for-profit institutions, which would include hospitals and many other places, require ratings that are substantially above investment grade.

In fact, there have been many hospitals, I believe, that have been downgraded from a rating that would support a bond offering to a BBB, which is still investment grade. But they do not have access to the capital markets.

The last point I would make about this, or two more. One is that I think this is a rapidly changing -- this is another area in which the latency of our data are a problem, because I think with the recent changes that have occurred in the economy and certainly in certain areas like California and New York. New York's hospitals are staggering, as a group, New York City's anyway.

And that there may be many more downgrades than have been reflected in the May data, that conversation you had with Standard & Poors. I would ask you to just refresh that. That may not be the case.

MR. KERNS: These conversations with both Standard & Poors and Moody's were this week. These are to date.

DR. ROWE: Okay, because I thought it said May in the material I had.

The last question I would have, and I don't know if it's for you or for some of the economists we have on the Commission or what, but did you have in your discussions with S&P this week -- let's take advantage of the fact that it's this week. Did you ask them what percent overall margin would be appropriate for a hospital to maintain a rating that would be -- all other things being equal -- adequate for them to access the capital market?

In other words, in your box here, market factors, one of them is access to capital. So my question is what kind of performance do these people who you're referencing and talking about judge to be appropriate -- all other things being equal, which they never are -- for them to consider that hospital to be eligible for consideration for a rating that would support access to the current capital market?

MR. KERNS: The simplest answer or the question there is it seems like you'd be referencing a total margin and not a Medicare margin. You've already pointed out the disparity between hospitals with strong Medicare margins and total margins. There's an inverse relationship there, as well. Rural hospitals, strong total --

DR. ROWE: I don't think that they care whether it's Medicare or what. Just total margin, what would be the number?

MR. KERNS: The short answer is, no, I did not ask that question. The other thing is I don't think they'd just be looking at total margin. They're looking at a variety of factors. But it was typified that for the muni bond market for hospitals, by both people I talked to at the two major houses, that it's strong right now and that there is access to capital.

I also would point out that investment grade or higher. It's not that 90 percent are rated BBB. It's that 90 percent are rated BBB or higher.

And third on that, it's hospitals or health systems. So they may have 90 percent of hospitals or health systems rated there, but when you have a 200 or 300 hospital system that has AAA, you actually are probably going to look at a much greater percentage of hospitals that have a higher rating than hospitals or health systems. So that 90 percent itself is sort of an understatement of the total volume of hospitals that have decent ratings.

DR. ROWE: I think for the purposes of -- I think you separate profits and not-for-profits. And the not-for-profits have some systems that go together as an obligated group for the purposes of underwriting bonds, but they don't have 200 to 300 hospitals usually. So I was really concerned about separating those two.

But that's very helpful. Thank you, Jesse.

MR. HACKBARTH: David, did you have a comment on this particular --

MR. SMITH: Yes, I did. Jesse just got to some of it. Jack, I wondered, there's always a little bit of confusion when someone talks about access to capital markets. With a BBB rating, you've got access to markets but it may be access to markets at a price you don't want. But I think we ought to be clear that there isn't a bright line here at BBB or above which is a go/no-go. There are price consequences and feasibility consequences, but a hospital with a BBB rating has got access to capital markets that may not choose to exercise -- it may not make sense to exercise it, but doesn't not have it. Isn't that right?

DR. ROWE: Yes and no. I think it is. It depends on where and what kinds of capital and how much. You can get $20 million chunks but you can't get big things, et cetera.

One of the problems, of course, David, as you know, is that insurance for hospitals basically disappeared after the Allegheny bankruptcy. So that's made it a somewhat tighter marketplace, as well as the recent changes. I think that's right. I think this is a spectrum of availability to access capital markets.

I'm delighted it's on the radar screen because a couple of years ago it wasn't as one of the considerations. That's all. I just wanted it in one of the considerations.

MR. SMITH: I think it's important to underscore something Jesse said, which is that margin is an issue for the bond market. It's not the only issue. Reserves would be an issue.

DR. ROWE: Right, philanthropy, debt, other debt, et cetera.

MR. SMITH: Ongoing capital budget requirements are an issue. So looking at the margin, particularly an annual margin, is probably a pretty small piece of the puzzle that a rater is going to look at.

MR. HACKBARTH: Before we get too far from it, it wanted to just quickly go back to the point about looking at total margins, all payer margins. I think that's important information that we ought to have and take a look at.

I do think we need to be systematic and consistent in our approach about how we use it, though. I don't think we can say well, it's relevant when we look at hospitals, but it's not relevant when we look at SNFs. So we've got to come to grips with that question.

MR. MULLER: Several points. Just one more kind of factual point on looking at the ratings. As Jack pointed out, up to about a year or so ago hospitals could get insurance to go to the bond market. And secondly, many states have state guarantee agencies.

So I just wanted to second the point, there's a lot of selection bias in looking at who gets ratings, because if you can't get a rating, then in fact, in many states there are state agencies and so forth that will guarantee it. So you can go. It's just important.

I'd be very cautious about extrapolating too much from the fact that these hospitals get these investment ratings, because the ones who can't figure out some way to borrow.

MR. KERNS: A comment on that. MBIA is the largest underwriter of bond insurance, and as I understand it it was up until about a year ago that they weren't really taking on new business, but that they are indeed taking on new business. I've spoken with people there a couple of times, as well.

MR. MULLER: I'm just saying if you do look at a period of years, certainly the '90s and so forth, until the Allegheny collapse, people would go to the MBIA and so forth, and they would also go to the state agencies in New York, Illinois, and others.

I want to come back to the factual point that I asked before. On page 12, the question that I asked before about all costs. Do we again have all costs on this calculation? On the middle column, the all payments? I know we had some debate about Medicare allowable costs and all costs.

MR. KERNS: Those are all Medicare-allowable costs. The non-allowables are netted out. The non-allowables make the big difference on the inpatient side.

MR. MULLER: Roughly what percentage do you think would be non-allowable, just as a percentage?

MR. KERNS: Best of our estimate, maybe about 3 percent to 4 percent.

MR. ASHBY: We really don't know. We're going to do a study on that.

MR. MULLER: If it's 3 percent or 4 percent, that could take a lot of the AAA away.

MR. KERNS: We are going to do a systematic review of the schedule A8 on the cost report, where those non-allowables are netted out. That's going to take some time. That's something that I'm going to work on this spring.

MR. MULLER: I'm just making the point that if it is 3 percent to 4 percent, and I understand Jack is saying that.

MR. KERNS: I would have a hard time standing behind any number.

MR. MULLER: But it could, on average, take the whole margin away?

MR. ASHBY: I would be really reluctant to assume it's anywhere near that large. And that's probably the reason why we're finally going to measure that. I'm not convinced that it's that large, actually, but none of us really know.

MR. MULLER: No, I'm just repeating what you told me. I didn't make my own estimate.

MR. KERNS: That's at a maximum. There are a variety of things that could bring that down, including that those things are sometimes paid elsewhere by Medicare, and then netted into the costs that are ascribed to inpatient.

MR. MULLER: The other point I would make is on the use of terms. Obviously a term like inequity is perceived by many people as a different term in differential, which may be a little less neutral.

When things are put into policy, and certainly DSH, for example, has been put into a policy for quite a while and IME as well, those are statements of purpose and mission that government is trying to secure. They may debate about whether they should or not, but they're in there. Whether one then wants to call the consequence of that as inequitable, I think, is probably a little bit more a value-laden term than I would prefer.

Certainly, looking at the distributions, I think, is very appropriate for us to look at. I think part of the concern we had, whether it's in the SNF discussion or in this discussion here to come, is these averages mask an awful lot of variation. I think one of the things we have to get at in the whole accuracy discussion is how much variation do we think is appropriate in these kinds of programs and how much adjustment do we want to make.

Let me ask one more question, which probably is more of Murray or everybody. In understanding the adequacy diagram that we had earlier, looking at all the factors in adequacy -- I don't want to recite them all again -- and then also looking at the update discussion. If we look at these questions of distribution, whether it's on SNFs or hospitals and so forth, my sense is if we're going to have this newer model of adequacy and update, then to also have redistributional questions and say that's part of the update discussion causes me to think that we're undoing the model you just created.

If you want to get into redistribution questions that should be, in my mind, a different question and the update question. So if you have adequacy and you have concerns about distribution, you shouldn't therefore -- maybe it was just a slip of a tongue that said well, we'll take care of that in the update. But I think we should, if we want to get into distribution questions, not call that an update question.

DR. ROSS: Conceptually, obviously you want to distinguish, I think, distributional questions from payment adequacy, which is how much money in the pool. But given the fact that no one, whether it's hospital, SNF, or whatever, is average, it's almost impossible not to think a little bit about distribution as you're looking at overall adequacy.

Overall adequacy is total trust fund disbursements and costs of caring for Medicare beneficiaries, at some level. But you can't avoid, at the same time, if you see large differences, asking whether those are appropriate.

MR. MULLER: No, and I'm not saying we should avoid it. But I'm saying, however, to immediately put that right back into an update discussion kind of takes away the model right in the beginning.

DR. REISCHAUER: But some of these payment systems have different bases for urban and rural. So it is relevant to ask is the urban base adequate? Is the rural base adequate?

MR. ASHBY: The primary reason we bring it up in this context is because the update gives a vehicle for instituting changes. I mean, we could address distribution issues separately and frequently do. But if we thought it was appropriate to make a distributional change, then taking it on to the update, as it were, is a way to get it done. But it's really separate from an update issue, per se.

MR. MULLER: If in fact one wants to think of the update as a more technical estimate of how costs are changing, rather than a kind of fudge factor into which you throw all considerations, whether it's considerations of Congress as to how much they are willing to afford, whether it's considerations of other kinds of things one wants to rectify.

I think part of the virtue of the new construct you've put forth is, in fact, to try to separate these things. I'm not saying that people then ultimately don't make some judgments here and there about what they're willing to do, no matter what the construct is. But I think it's appropriate, if we're going to go with this new construct, to honor the construct at least for a while.

MR. ASHBY: Yes, but by keeping them separate, I think that we can still honor it. If we look at payment adequacy and we decide payments are adequate, then the adjustment is zero. If we look at the cost increase to the next year and we decide market basket is the right figure, then market basket is it. And then thirdly, if there were an adjustment to the base rate up or down for some group of hospitals that we thought was appropriate, we would tack that on to the end.

And by keeping the three pieces separate and on paper we're sort of accountable for what we're doing. Does that make sense?

MR. MULLER: I think that's the right way to think about it.

DR. STOWERS: I had a question about a little different kind of variability. We have an overall of 3.8 percent. What's the variability in those that are above and below a positive margin? For example, what percentage of the total are going to be below zero, as far as that?

MR. KERNS: In 2002, 45 percent of hospitals would have a negative total margin. I'm sorry, negative overall Medicare.

DR. ROWE: That's a Medicare margin.

MR. KERNS: Negative overall Medicare.

DR. STOWERS: I'm talking total margin.

MR. KERNS: Oh, negative total margin in 2002? I don't have a projection of that. I know that it was about 37 percent, 36 percent in 1999.

DR. STOWERS: But I think that distribution, when we look at what the impact is going to be across the country, is important. And so somehow in there I think that may look -- I know we have to look at it in a global way, but when you look at impact in the field, and we look at how we're distributing the funds, I think that's still important.

The second point that I had is there's a lot of large urban hospitals that do not receive a significant amount of IME funding. I would like to see a breakout of those margins for larger urban hospitals with a significant amount of graduate medical education and those without to really know how much of those margins are due to the fact that they're a large urban hospitals or to the fact that they're receiving the IME uncompensated care and low income and all the other -- so I think that breakout, I think we may be grouping too much together in that large urban category.

MR. HACKBARTH: Can I pick up on Ray's point there? When I look at page 12 in the table, it's striking to me how important IME and DSH are in determining the winners and losers under this system. It's real easy for us to fall into the habit of saying well, everybody who's in the urban category is getting these payments to the same degree, which I don't think to be true. I don't think that's the case.

And so within some of these categories then, our old tables look okay. This category looks like it's got a high margin. In fact, there can be a great disparity, depending on how much of the IME and DSH money they get.

MR. ASHBY: Let me respond to that in a little different way. We were actually asked this year to do further analysis on the factors that determine those with high and low margins, the winners and losers if you will. We looked at the numbers that we put up today as sort of like the first installment on that. Because when you look at just the limited groups that we've looked at, it becomes exceedingly obvious, as you say, that the DSH and IME play a major role in determining the hospitals at the tails.

But that was the first installment. We do intend, in the next cycle, to do a more involved analysis on what are the factors, what is the distribution and what are the factors that govern it. I think we will begin to shed some light on that.

DR. ROWE: If we're going to get -- it sounds like we're having discussion, as we point out, rather than making a decision, to get some additional information, I think that's useful. Some of these analyses about the distribution would be very helpful in terms of the subsets and the ones that are underwater.

I think the other thing that if we could get just one page on I think would be kind of interesting is that despite Dave Smith's experience in city government and mine in hospital management, neither of us would get hired by Moody's or S&P. It would be interesting to get somebody from one of these places to actually give us a statement with respect to the not-for-profit hospitals and the relative importance of different characteristics. And then we can sort of settle it, since it is on your list of market factors. And get a statement from them about their assessment of what it's like right now, what the issues are, and how important one thing is versus another.

MR. ASHBY: As managing this process, I do have to ask how much we're thinking about this. But perhaps we could do some limited distributions. As you say, we could look at what the percentiles are within these broad groups that we've looked at. I think if we did that before subtracting out the above cost IME and DSH, and then after you'd find that the distribution is a lot less afterwards. But I think that basic level of analysis we probably could do for next time.

DR. ROWE: For overall as well as Medicare.

MR. ASHBY: Right.

DR. ROWE: And we could get a letter from one of these rating agencies in a week.

DR. STOWERS: I think what I'd like to see on the GME thing, our experience is the large urban hospitals that do not have the graduate medical education are actually doing a lot better than those with.

MR. ASHBY: Medicare or overall?

DR. STOWERS: Overall. So I would be interested to see how that works out on the distribution.

DR. WAKEFIELD: Jesse, we talked a little bit about the issue of access to capital and the importance of that. I'm thinking about access to capital now in the discussion that you provide related to -- well, in the text on the bottom of page five and six.

I'm trying to think about the relevance of this discussion to rural hospitals, for example. And so when I look at access to capital to improve equipment and physical plant and it's okay, but what's the relevance of that indicator, i.e., bond ratings for example, for access to capital for rural hospitals since about 45 or so percent of them are publicly owned by counties or towns? So what's the relevance of something like a bond rating when we think about access to capital for this big category of rural hospitals.

And also, what's the relevance of discussion -- and so I'm trying to think about what's another way of getting at that issue of access to capital? Because clearly it's important for small rural hospitals, as well.

The other part of this, the indicator of their stock price, as well. In terms of stock prices, only about 8 percent of rural hospitals are for-profit, and I'm not sure how many of those are going to show up on any sort of stock index. But only 8 percent are for-profit, I think, of rural hospitals.

So my question is is there anything else we could be looking at or thinking about to try and get a handle on access to capital if this is somewhat less relevant to those hospitals? Anything else you can think of?

MR. KERNS: I'm open to ideas.

MR. MULLER: Just a quick follow-on to Mary's question, since a lot of the safety net hospitals in the country are, in fact, governmentally owned, when they borrow for their capital needs it's not done as a hospital. It's done as a governmental agency.

So you can look at those numbers of borrowings for hospital type, and kind of look at the trends, whether it's drying up and so forth, by the New York Cites and Chicagos and LAs of the world, and so forth. You can get some sense of whether that's going up or down in terms of their borrowings.

MR. HACKBARTH: I look at page 12 at the question that I keep coming back to is is the system healthy? Is it functioning properly when the only way to have a positive margin -- I may be overstating this a bit, but allow me to do that -- is if you get payments that are by design unrelated to cost, namely IME and DSH?

If you're just under the basic system, you're going to lose money. That doesn't sound like a very healthy situation to me.

MR. MULLER: You really want to go that far and say they're unrelated to costs?

MR. HACKBARTH: If we're talking about the half of IME -- unrelated to the Medicare costs. Yes. So if we're talking about the so-called subsidy piece of IME, it's beyond what the formula shows. And then the DSH, by definition, is for non-Medicare patients. So we've got a basic system where you don't do very well unless you get these supplemental payments unrelated to your Medicare costs. That's what the table says to me.

MR. MULLER: There's some part of IME that obviously is related to costs. There's DME that's related to costs.

MR. HACKBARTH: This only has to do with the half of IME unrelated to costs.

DR. NEWHOUSE: I want to try to frame the debate as I was hearing it. First of all, on the distribution side, there's at least two policy issues running through here. One was alluded to by Bob, the large urban differential of one or one plus percent relative to -- by large urban here is meant, I believe, metropolitan of 1 million or more population, if I remember right.

So relative to everybody else, even holding things equal, they get another percent or so.

MR. KERNS: 1.6.

DR. NEWHOUSE: 1.6; thank you. However, as I recall, that does come out of the regression. So in a sense, there's just basically some higher costs there that we can't otherwise explain with what we've got in the --

MR. ASHBY: No, no. That's not the case, actually. As an advance on what I was just going to say, I'll just go ahead and say it now. The multivariate findings were that there is, in fact, no difference between the hospitals in major urban areas and other urban areas. In fact, the other urban areas is actually a tad higher.

There is, though, a difference between the costs in urban areas in general and the costs in rural areas. The rurals are lower. That leaves you wondering whether they're lower because they didn't have the resources to spend. But be that as it may, there is a difference between urban and rural. There is not a difference between large urban and other urban.

DR. NEWHOUSE: Thanks. So that's one policy issue on the distribution side. The other one is the one that we've just been mostly talking about, which is the roughly half of IME that's above so-called empirical level or the subsidy. I just wanted to step back and try to put both of those in a somewhat larger picture that also actually goes to the point about the distribution of hospitals and what percent they're in, have negative total margins, and so on.

We have set up a system and have lived with it for lo these many years now that attempts to be a national system that has some adjusters in it for local conditions but those are going to inevitably be imperfect. In particular, the system really ignores local market conditions.

So this comes up in the discussion where I think Jack started out to lead with the total margin and the rurals. Private plans can exploit the competition to a greater degree in the urban areas than they can in the rural areas. Put it another way, rurals tend to have more market power. It shows up in the total margin.

The question is should Medicare take cognizance of that, whereas it doesn't now because it basically has a uniform system. As I said, it doesn't really attempt to measure competition in the local market. One could regard the two policy things that we're dealing with, the urban differential and the IME subsidy, as very crude corrections for that.

By the way, I should say I personally would get rid of the urban differential and I would get rid of the subsidy in IME. But in trying to think about a framework for how to think about these issues, I think one of the relevant things is should Medicare, in some way, take account of local market conditions.

The other, and it's quite relevant, I think, for the negative margins, is what does Medicare do about hospital circumstances that are heterogenous other than the local market conditions? Different unmeasured case mix, different management capabilities, different degrees of philanthropy, different degrees of support from local governments or state governments.

Hospitals come in all sizes, shapes and flavors. Medicare essentially tries to strike a rate that falls somewhere in a quite diverse distribution. If it goes toward the high end of the rate and lowers the percent with negative margins, it's going to essentially give windfalls to the people that are in the better off circumstances and conversely, as it pushes tighter, it will disadvantage the people at the high end. It seems to me that's just a fundamental problem here that we have.

But what I think we have to come to grips with is that we have sort of a one size fits all system in the PPS and inevitably there's going to be things that stick out that are going to want to be sanded down. It's a question of how far we go along that path.

DR. REISCHAUER: With respect to whether Medicare should take advantage of differential market power in different areas, I would suggest that the answer is a clear no because to the extent it did it would raise the cost of insurance in those areas, private insurance, and increase maybe the number of people uninsured.

It has an ability and an obligation, I think, to exercise its average market power in the nation --

DR. NEWHOUSE: As I said, given where I came out on the things, I would not take advantage of it, either.

DR. ROWE: Can I ask a question about that, Professor Reischauer? Why is it if the previous observation about the reciprocal nature of the Medicare payments and the other commercial payments holds, then if we paid more in rural areas for Medicare because the Medicare margin is down, one might expect that that would reduce the payments from the non-Medicare payers and the overall cost of insurance in that market would not go up.

DR. NEWHOUSE: That should hold in competitive markets, that reciprocal thing. Once you have monopoly, then there's no reason why the hospital shouldn't exploit its market power.

DR. ROWE: I don't know what the experience has been with respect to these hospitals.

MR. SMITH: But, Jack, that does assume quite improbable behavior. Without any change in degree of market power available, that prices in the private side are going to be reduced reciprocally to increases on the Medicare side. I can't imagine why that would happen.

DR. NEWHOUSE: That's the data.

MR. KERNS: Medicare improved as a payer in rural areas for the last eight to 10 years, and private payer payment-to-cost ratios didn't budget. Even as costs went up faster in rural areas.

MR. SMITH: That was my point.

DR. ROWE: So the point is that this reciprocity doesn't count there, or doesn't occur there?

MR. KERNS: It's correlated, there's no causality.

MR. MULLER: It's correlated with the weights.

MR. HACKBARTH: I'm a little confused in this exchange. It would be helpful to me, Bob, if you would restate your point one more time. Let me make sure I've got it.

DR. REISCHAUER: I'm not sure now that we're on the same wavelength here. But I do think, and you're telling me the data doesn't show this, that if Medicare were a better payer in rural areas, Jack would be paying hospitals less in those areas because I think a lot of these hospitals are municipal county hospitals and that they are trying to cover total costs and not trying to maximize rent.

DR. ROWE: That was the point of my question. That's what I'm trying to clarify. That's what I thought he was saying.

DR. NEWHOUSE: I don't think we've seen those data on total margins.

MR. KERNS: You've seen rural total margins for 10 years. You've seen rural payment-to-cost ratios for private payer and for Medicare for the last 10 years. Medicare improves each year. Private payers do not fall a bit. 134 percent of costs for 10 years, from '90 to '99, even as Medicare improves, say six to eight points.

DR. NEWHOUSE: All right, that confirms what I thought, which was that under competition that you will get this inverse relationship. And with market power, there's no reason to observe it.

MR. SMITH: I thought Jack was headed in a different direction. I'm struck by another sort of crude balancing. There is, and partly intentionally and partly as an artifact of two different payment policies. But the Medicare margin and its distribution as a result of IME and DSH payments does, in an important way, on a geographic basis compensate for the higher overall margin that's been sustained. We don't know how to deal with either of those phenomenon entirely through the Medicare payment system.

But we've got this sort of crude balancing mechanism. It's a subsidy in the urban areas who can't avail themselves of the same kind of market power that's available to rural hospitals. Medicare payments don't quite compensate for costs in rural areas. The inverse is true, particularly in large urban areas.

You never actually own up to having designed the system that way, but I'm not sure that the outcome is not better than if we tried to tinker with each of the sort of odd balancing items that have ended up here. I'd be very cautious about trying to make

Medicare margins equivalent in these situations where very different market power is available to the institutions.

I think if you look at the total margin data, as modified by Jesse's observation that the rural/urban distinction is held, and then you look at the Medicare margin data, there is a crude reciprocity there that may be the outcome we'd want, and we couldn't get there if we tried to get there with precise Medicare payment policy.

MR. HACKBARTH: Are we saying that we want to do is have Medicare pay money to hospitals that lack market power? If they lack market power, it's because there are lots of other hospitals there to serve Medicare beneficiaries and lots of competition. I'm not sure that we want to pay more to hospitals that lack market power.

I thought the more plausible argument is that these hospitals carry other burdens that the federal government needs to recognize.

MR. SMITH: No, that was precisely my point. But because they lack market power, they aren't able to compensate for those other burdens with tools other than public payment policy.

MR. HACKBARTH: But then that gets us back to the question I raised earlier. If in fact we start to say, in formulating Medicare payment policy we look not just at Medicare margins but total margins, where do we draw the line? Does that apply to every class of provider? You open that door a little bit and a whole lot of people will come in and say well, I qualify. My total margins are bad, pay me more.

MR. SMITH: Most of us weren't around -- Bob and Joe may be able to help. But clearly, DSH and IME have their roots in precisely that observation. And folding them into Medicare was taking advantage of an available tool in order to do precisely what you just said, which is address the discrepancies in the ability of hospitals to maintain positive margins.

DR. NEWHOUSE: Actually DSH and IME, I would have said, differ on that score. That description applies to DSH and not to IME. IME was a recognition right from the outset that teaching hospitals had higher costs and something was going to have to be done about that in the system. The subsidy got built in because people were in a hurry to get the legislation through and that was kind of a crude approximation. The original way of dealing with it had some methodological flaws and they said well, we'll just double the empirical level. And we've been kind of working our way down from there.

MR. HACKBARTH: We need to move on to the next step in this analysis which is Jack talking to us about the inpatient update.

MR. ASHBY: We actually had two remaining issues here on the inpatient side. One is the redistributional one we've already talked about a bit, and so I'll just kind of customize my comments there. The other is the adjustant for cost increases in the next year.

Taking on the cost increases for the next year first, this begins with our forecasted increase in the hospital market basket, which is 2.9 percent. I would just add by way of side commentary, that this is a brand new forecast that just came out in the last few days. The forecast has been reduced from the previous one, presumably reflecting national events and a downturn in the economy.

Other considerations that might go into this adjustment for the next year. First off, let me say that lacking any ability to really measure either the cost impact of technological advances or productivity change, we are basically planning to assume that the two offset each other. I would comment that we have a tech pass-through payment on the inpatient side now. But by law, that is to be implemented budget neutral and so basically should not be a factor in considering overall payment level.

A different kind of issue, the cost of disaster preparedness is especially likely to be a major issue in the coming year, but we've gone into this with the assumption that any new federal monies will not be routed through Medicare, which is probably appropriate given that the goal is to protect the entire population. So again, we are not proposing to deal with this.

In theory there's a third issue that might come into play here, and that is that we might project per discharge cost increases to be below market basket because we expect further decline in the length of stay. The reason we might expect the further decline is that we have had declines 10 years in a row and our National Health Indicator Survey strongly suggests that we're going to have an 11th year of decline in 2001.

But on the other hand, there is some evidence that the length of stay is stabilizing. That is, the annual reductions are getting smaller. And then we have to say, in fairness, that as with the technological changes, we have no real way of making a prediction of what's going to happen way out in 2003. So we were not proposing to go down this path either. We're putting it in the same class as the technological changes. They are sort of small factors that we really can't deal with very accurately in a prospective way.

So that leaves us with the market basket forecast as the best estimate of the increase in efficient providers costs. To get back to Ralph's comments of a few minutes ago, we would indeed apply that to all hospitals because the cost increases to the next year would be expected to be the same for all hospitals. By comparison, the current law is market basket minus 0.55 percent.

Now, turning to the redistributional issue, as Joe pointed out the base rate is 1.6 percent higher for hospitals in large urban areas. What we wanted to focus on here is -- this is the perfect place for use of our margins, having subtracted out DSH payments and the portion of IME above costs, because it is that level when we're looking at our core Medicare payments that are to relate to the cost of care that we see that the margin for hospitals in large urban areas remains about four percentage points higher.

So irregardless of what subsidy type monies the system has put out there to help these hospitals with their market conditions, they're four percentage points higher even before considering those various subsidies.

This isn't supported by the cost analysis, as we pointed out a minute ago. So we thought that there's a policy issue here. There is the possibility that we might want to, perhaps not in one swell swoop, but we might want to narrow the gap in the base rates by subtracting a small increment from the update that would otherwise apply for large urban hospitals and adding a small increment for other urban and rural hospitals.

It happens by sheer coincidence that the two groups are weighted equally. So for example, if we were to have a plus 0.5 and a minus 0.5, it would be budget neutral naturally.

Ideally, we would probably want to continue to treat the other urban and the rural groups as a single group to avoid going from two to three base rates. If anything, we'd like to go in the other direction, towards one base rate with adjusters as appropriate. So that's a consideration to keep in mind.

Then, the difficult part is that obviously we should consider that a prospective change, in light of other changes that may affect the distribution of payments between these groups, and there are several potential of them. So it creates a rather complex picture.

If we could look at the chart, the first one of them is the reduction in the IME payment that's scheduled to go into effect in 2003. I want to remind everyone that that was taken into account in the modeling. So the 3.8 percentage that we saw is after that reduction. But we put it up here for information purposes because we thought that it might be considered relevant in a dynamic sense. You'd have to ask whether we would want to reduce the gap in the base rates in the same year as this IME reduction takes place. Because for some hospitals, they would have to absorb both simultaneously.

The second one you see there is the adjustment for occupational mix in the wage index. This will indeed, on average, reduce payments to hospitals in large urban areas and raise them form hospitals in rural areas. But this is only on average. And we don't really know now much.

An analysis we did some seven or eight years ago suggested the answer might be in the neighborhood of 2 percent of the bottom and the top. But that's old data only from one state. Basically, we don't know.

We're also not sure how this would play out in the middle group, the other urban areas. Most assuredly there will be some combination of increases and decreases, and I couldn't even conjecture where the average would fall. And then the big problem here is that this isn't going to happen until about 2005. So we have an issue that's somewhat analogous to our RUGs in SNF this morning. What do we do for the three or four year period before this takes place?

Critical access, we only mention it in the sense that, as Jesse mentioned, there are 200 hospitals that have gone critical access that are not yet reflected in our analysis. And so we would expect to see a further increase in payments for those rural -- the average that you saw for rural hospitals will rise by these 200 hospitals dropping out because most of them have negative margins.

Then lastly, and probably most problematical, is our series of recommendations. This includes both the reform of the disproportionate share system that we published in March and our rural recommendations in June. This presents a very uncertain situation because virtually none of these, as everyone knows, has been enacted, although there has been Congressional interest in virtually all of them. We just simply haven't gotten there yet.

The DSH reform impact numbers that you see there, this is actually new analysis that we just finished up in the last couple of weeks. You'll see that done budget neutral, our proposal would significantly raise payments for rural hospitals with a small reduction for urban hospitals.

Our other recommendations, you see the numbers, but those are very basic. Depending on exactly how these are specified, the impact could be significantly greater. We really can't do an impact analysis yet, because some of these recommendations were in a very general form that would require further specification before we'd know what would happen.

So these are the things that are all sort of in the back context as we consider the possibility of this adjustment to the base rates.

MR. HACKBARTH: Would it make sense, Jack, to bring Chantal up here to talk about the outpatient piece?

MR. ASHBY: It would, yes.

DR. WORZALA: Good afternoon. Now we're going to turn to the hospital outpatient update.

The law established the update for the outpatient PPS through 2002. And in the absence of additional legislation, in 2003 the Secretary will establish the update based on the hospital market basket index used for updating the inpatient PPS. However, no outpatient PPS process has been described in regulation to date.

The law does allow the Secretary to adjust the update in response to excess volume growth. MedPAC has recommended that the Secretary refrain from doing this and has recommended an update approach that takes into consideration the factors affecting efficient providers costs. You've never heard that before, I'm sure.

As with the inpatient PPS, MedPAC will make an update recommendation that follows our conceptual approach outlined this morning. This is the first time that we will make an outpatient PPS update recommendation.

The first consideration in determining the outpatient update is any increment to be added or subtracted due to our conclusions regarding payment adequacy. As we just went through, payment adequacy was judged at the level of the hospital. And so we would have to think about allocation of a payment adequacy adjustment to the inpatient and outpatient payments.

One approach would be to treat them equally, with the same increase or decrease applied to both. For example, this is purely hypothetical, if we determine that hospital payments as a whole are 5 percent too low relative to costs, we would add five percentage points to both the inpatient and outpatient updates.

Another approach, however, might be to make different adjustments in each sector. We would do this if we thought that payments relative to cost were more or less adequate for one sector versus the other. For example, we might think that the cost basis overstated for outpatient services and understated for inpatient care. And in fact, the limited information that we have, which comes from a study using 1991 resource cost data, does suggest that outpatient costs are overstated by as much as 15 to 20 percent with inpatient costs correspondingly understated. We would like some more recent data, but we don't have it.

If we adjust the margins to account for that difference in cost allocation, inpatient margins do still remain five to six percentage points higher than the outpatient margins. Just as a point of information, when thinking about allocations between the two sectors, the inpatient payments are about five times larger than the outpatient payments.

Okay, so that's it on sort of follow up from payment adequacy. The next consideration in the update would be expected changes in costs for calendar 2003.

The latest market basket forecast is 3 percent, which is slightly higher than the market basket for the fiscal year 2003, which is 2.9.

The next update factor that we might want to consider on the outpatient side is cost changes due to technological advances. This is a little bit tricky on the outpatient side because the payment system does have two mechanisms in place already to pay for new technology. One of these mechanisms, the new technology APCs pays for a completely new service. So you have a completely new APC code.

It is not budget neutral, which means that the costs of this type of new technology are funded through the base payment stream and do not therefore need to be taken into account in determining the update.

The other new technology payment mechanism, which are the pass-through payments for inputs to an outpatient service, is implemented in a budget neutral fashion and it's therefore analogous to the recalibration of relative weights among services. Therefore, we may want to consider the net increase in costs due to these new technologies after taking into account, of course, any technologies that decrease costs.

Of course, as a practical matter, and is the case on the inpatient side, we do not have a reliable measure of the net change in costs due to technological advances in outpatient services. So we may wish to follow the same logic as has been suggested before and assume that cost increases due to technological advances are offset by productivity gains.

As a further note on the outpatient side for the year 2003, we do not anticipate any significant pro rata reductions for the pass-through payments because the volume of items that will be funded through the pass-throughs should decrease dramatically in comparison to 2002.

A final factor that might affect outpatient costs in 2003 is the continued roll out and implementation of a relatively new payment system. Hospitals have certainly experienced some cost increases due to information systems and improved coding that's been needed for the PPS. However, most of those costs should be absorbed before 2003.

In addition, experience from other new payment systems has shown that hospitals generally do constrain their costs in response to the uncertainty introduced by a new payment system.

So now I'll just turn the presentation back to Jack to present a summary of the discussion.

MR. ASHBY: We can put up this last overhead and I was only going to do about 10 seconds worth, and that is we thought it might be useful to create this little framework -- it's actually a scoreboard, I guess, for the factors that we might work through in our decision.

The top line represents basic payment adequacy. If payments are adequate, zeros. But if payments are more or less adequate, we have a number on that top line. And it raises the second question, which is do you want that number to be the same on the inpatient and the outpatient side? Hence, the two lines.

Then vertically, on the inpatient line only, we have the question of possible upward adjustment for other urban and rural areas, downward adjustment for large urban areas. Then we go down to the next line, that has the two next to it. There's the adjustment for next year. That would be on the order of 2.9 percent. I guess it was three points for outpatient. And then the bottom is just the sum of the two across the board.

So that gives you an idea of what vehicles we could use for our various decisions here.

MR. HACKBARTH: Jack, can I go back to page 15 and the discussion of eliminating, perhaps in steps, the urban/rural differential in the base rate?

MR. ASHBY: I'm sorry, I was scrambling for my paper.

MR. HACKBARTH: The urban/rural in the base rate. You say one of our options is to eliminate that or do so in steps?

MR. ASHBY: Yes.

MR. HACKBARTH: This was an issue we discussed when we did the rural report. It was not one of the options that we included in the recommendations we included in the final report. Could you just refresh my recollection as to why we didn't do it then? Has anything changed?

MR. ASHBY: We cast it in terms of there are both advantages and disadvantages to do so. I think the difference really was that we were focusing solely on rural hospitals at the time. And the multivariate cost of analysis does indeed suggest that costs are lower in rural areas than they are in urban areas. So I guess the suggestion, all else equal, is that perhaps there's cause for this differential.

The problem is that now that we've sort of broadened our look at it, that is not the case with respect to the large urban, other urban split. There really appears to be no justification for that.

So if you went solely on the cost findings, you'd have some support for it with respect to other urban. You'd have some support against it with respect to rural. So there's no clear answer.

And that's essentially what we said in the spring. there really is no clear answer to this.

MR. HACKBARTH: Help me connect that now to the table on page 12. We're saying that the differential is arguably justified because rurals have lower cost. But what page 12 seems to suggest is that the payments are even more lower.

MR. ASHBY: Right, but some of those payments though, of course, are outside the inpatient arena. On page 12, we're looking at the all Medicare --

MR. HACKBARTH: That is a switch.

MR. ASHBY: Some of the losses are indeed not coming from inpatient. These rural hospitals have a lot of outpatient care and that's where a lot of it comes from, and the SNF and home health as well.

But in the broader picture, in the broader sense, you're right.

DR. NEWHOUSE: I guess I'd like to propose that our presumptive policy would be to go with the empirical data and create a policy around exceptions. Under those, as I hear it now, what that would imply in this domain is that actually the large urban category would get expanded to all urban, and the whole thing would be recalculated. Is that right, Jack? The empirical data show costs higher in all urban relative to rural and no significant difference between large and small urban?

MR. ASHBY: It is true.

MR. LISK: That's when we had a volume adjustment. When there's no volume adjustment, there really is no significant difference.

DR. NEWHOUSE: We have to show it both ways.

MR. LISK: Because this current system doesn't have a volume adjustment. So when we were doing that modeling, we had the volume adjustment in there, and that's where rural came out lower in that case.

DR. WAKEFIELD: So without a volume adjustment --

MR. LISK: Without a volume adjustment, there basically is not a significant difference between the groups.

DR. WAKEFIELD: The groups being?

MR. LISK: Large urban, other urban, rural -- actually, there probably is slightly significantly higher costs in the other urban group. And the rural group is similar to the large urban. So in fact, the other urban group actually has higher costs. That's from the regression.

That's probably circumstances of market competition for managed care, which is more prevalent in the larger urban areas, and has helped push down costs and, in effect, pushed down Medicare's costs in those markets compared to some of the smaller other urban markets where that's not the case. And I think that's the explanation for that.

MR. ASHBY: So that does change the picture a bit. It seems to suggest that perhaps there's little justification for a differential at all.

MR. HACKBARTH: Joe, would you restate the policy direction that you were --

DR. NEWHOUSE: The general thrust would be a presumption for what we've called elsewhere the empirical level generally, with exceptions. We can always choose to make exceptions. But I fear we'll always be making ad hoc fixes and then maybe the ad hoc fix will turn out to need another ad hoc fix next year. And we're doing it on out of date data.

Now admittedly, the empirical level is out of date data, but I'm more comfortable with trying to let us be as data driven as possible in our adjustments to payments across types of hospitals. I'd suggest as kind of a guiding principle that's what we do here.

Now admittedly, the empirical level is going to depend on what the total adjustments in the system look like, as was just brought out with the low volume adjustment. But I presume we can handle that.

MR. HACKBARTH: Just so that I understand you're saying, let's do this analysis and if it suggests that there isn't an urban/rural differential, let's eliminate that. And also, let's go with the empirical number applied to IME as well? Okay.

Other comments?

MR. MULLER: I'd also want to come back to the question on page 12, the Medicare margins and the dialogue I had with Jack earlier about the non-allowable costs. Obviously, if they're trivial then it doesn't change the table in any significant way. If they are at the 3 percent or 4 percent level and the Medicare margins would, let's say, be at zero. Because I mean those costs, and I can understand the policy purpose of saying they're not allowable for Medicare -- for example, some of those costs have to do with advocacy, have to do with philanthropy, and so forth, which are ways to try to secure funding for keeping these institutions going. But they are real costs.

I think very few people should argue that one shouldn't try to raise money for travel, institutions and so forth.

So if they do start approximating that roughly 4 percent level, and certainly I don't know what the number might be, but I know it's more than a trivial number. And therefore if, in fact, the margins are zero, that's an important thing to know.

If the overall is zero, there could still likely be the kind of distributional spread that is on this table. Just everything kind of moves down a little bit. The fact that Medicare has chosen not to allow certain costs does not mean those costs do not exist and certainly they are borne somewhere.

DR. REISCHAUER: Just a question to Jack. Do those costs reappear in the total margin table?

MR. ASHBY: Yes.

DR. REISCHAUER: And so do uncompensated care costs and the costs that Aetna doesn't pay?

MR. ASHBY: Everything.

DR. REISCHAUER: Everything reappears.

DR. STOWERS: I just had a question, Jack. You know, on page 12 again, the IME above costs is a 50 percent number that's a huge factor in this. I know that historically it was originally based on the 1980s numbers. Is this based on current data, that's 50 percent?

MR. ASHBY: We've redone that analysis a half dozen times over the years. The latest one was done for our GME work two years ago, I believe. So it's approximately two years old.

DR. STOWERS: My whole point that since it is such a huge factor in here, I think it would be great to explain that in the text, that this is a current number, that it is justified.

MR. ASHBY: Right, and it is empirically driven.

DR. STOWERS: Because I think in a lot of people's minds, that's an old number. It might be good to explain that.

DR. WAKEFIELD: I just want to share my perspective that I think that Medicare should be paying its fair share and that fundamentally we ought to have the payment as precise in its remuneration for costs of providing care as we can with an inefficient system.

I'm a little troubled, and so I'll look forward to more discussion about the fact that because rural hospitals have higher total margins that somehow that might mean that we don't have to be too concerned, in a way, paying its fair share within that environment if other payers are paying more. I'm troubled by that notion.

And also, because I think if that is the approach that we take, then we also apply it to other settings, as well. Not just hospitals, but our discussion earlier about long-term care facilities, for example. And frankly, I wouldn't be a bit surprised if we don't have some real problems with Medicaid paying its share of the freight for long-term care Medicaid beneficiaries.

So the question is do you build in that kind of cost shifting, or do we try and ensure that the payments are adequate.

Secondly, I'd be interested in knowing to what do those higher total margins really translate to, in terms of total dollars? I think on average, for example, rural hospitals have less cash on hand. They tend to have older physical plants. So when you think about higher total margins, but percent of what? What are the real dollars behind that and what can you do with that additional X dollars anyway? So I guess that's another factor that plays in.

A third thing is we do have payment policies that may or may not be accurate in terms of special payment policies for rural facilities, special payment policies that build in some disparities or differences through DSH and IME for urban hospitals, for example.

But I certainly don't see this as being any sort of equivalency given the lay of the land right now. So just based on what I was hearing a little bit earlier, I really want to make sure that we're not assuming that they're both kind of taken care of. Because if anything, I'd say rurals would probably step up on the plate and be happy to do a switch tomorrow in terms of the payment policies reversed, if there was in fact any sort of an equivalency here.

So I guess just sort of a reaction to some earlier discussion, and I know we'll be coming back to all of it again.

MS. RAPHAEL: The only thing that I want to be sure that I fully understand, based on what Craig said, we're saying that because larger urban areas, in responding to managed care, reduced their costs somewhat or had the ability to reduce their costs somewhat, we believe the base payments for that sector ought to be reduced and Medicare would accrue the benefit of those reductions? What am I missing?

Is that a correct interpretation of what Craig said?

DR. NEWHOUSE: I'm not sure. There's two different issues One is the issue of the total amount of money in the system which this really goes to, and the other is the distribution of that money among different classes of hospitals.

We've heard the empirical data on the strength of the rationale for the differences in the distribution. So if you did it budget neutral, you would reduce the large urban and you would increase everybody else by some amount, something under a percent, probably.

MR. HACKBARTH: Any other comments? Or solutions? Solutions would be welcome. Okay, I think we're done for now.

Just to make it clear, the floor is open for questions and comments about the outpatient piece, as well. Joe, did you have something you wanted to say on that?

DR. NEWHOUSE: I don't know to what degree other people share this. I had a -- this was really through a glass darkly, or maybe darkly squared. I mean, I didn't know how to react to these numbers. Admittedly, some decision has to be made, but Murray's comment or other people's comment about maintaining stability and Carol's comment about home health may be apropos here. That doesn't lead us to an update number, but probably we ought to try to hold with what we think expectations are for the moment, until we have some data.

I didn't know what to do about the -- but I was interested if anybody had any ideas about -- that was why I brought up the notion that we didn't talk about outpatient.

DR. ROWE: What's going to be the timing of our consideration with respect to these issues?

DR. ROSS: The usual timing. You'll make a decision at the January meeting.

DR. ROWE: So are we going to likely get some draft recommendations around Christmas or sometime?

DR. ROSS: We're going to try and disentangle, do some forensic work on the transcript here, to see what direction all this leads. I mean, the world is a little bit more complicated this year in past years. Part of that is self-inflicted because of the approach we're taking, and part of that is inflicted by the reality here of trying to look at an overall measure of payment adequacy, figure out how to deal with it vis-a-vis inpatient versus outpatient, thinking also about the distributional issues. And then given that the outpatient system is still new with all the hold harmlesses in place.

We'll produce a couple of recommendations, but if there's specific directions in addition to some of the suggestions for additional cross-tabs and data points that you've asked for, we'll try to get back to you. If there are other things you specifically want on the table, now is a good time to --

DR. ROWE: That's what I'm asking, Murray. I'm actually just trying to -- you know, in thinking about some of the meetings we have, we have discussions of draft recommendations in great detail, and then we think about it, work on it, send some e-mails around and vote on it at the next meeting.

We're far from those discussions of the draft recommendations at this point on these issues. Very big policy issues looming, being lobbed out onto the court here. And so it seems to me that it's going to be hard to get to the point where we're really going to make a decision about this at the next meetings. That's why I was asking whether, in fact, we need to do that, what the schedule is, et cetera.

DR. ROSS: I don't think we go into the January meeting with the notion that we're going to perfect Medicare.

DR. ROWE: I'll come anyway.

DR. ROSS: But we want to get some of these issues out on the table. If the Commission is not ready to make recommendations on it, so be it. But there's a discussion process here. I mean, you've seen a lot of different types of information at the last meeting, at this meeting, that we really haven't encountered before, that the Commission hasn't had a chance to think about.

DR. ROWE: That's my point. So these decisions have to be published when, in the March report?

DR. ROSS: This is the March report. You're on the hook for a payment update recommendation.

DR. ROWE: And that decision, in order that it be published in the March report, has to be made by the January meeting.

DR. ROSS: The January meeting.

MR. MULLER: But given the last chart and the question of redistribution, which obviously becomes politically than almost anything else to deal with. It kind of makes market basket look tame. So I think therefore having numbers that obviously are in play and move around, even from what we got on Monday to today -- I mean, understanding there's always updating going on, so I'm not criticizing that. But these numbers probably will more a little bit more between now and when we get them next month.

So whether it's the question of what the difference between large and other urban, or between urban and rural. My question about what costs are in or what costs are not in. I think if we're going to go to this kind of framework and really take on some redistributional questions, we should make sure we have time to really kick those numbers around a little bit rather than just kind of saying here they are but they may change in a few days because -- obviously, we're up against a time crunch, but the kind of spread in those numbers.

And this goes back to the SNF discussion, too. It's not just the hospital discussion. Once one gets into redistribution, one has to have a pretty good sense of what the numbers really mean, rather than just saying in general. I understand Joe's point, he wants to go with the empirical base. But it's very important to know what that empirical base is.

DR. ROSS: But as we talked about throughout the day, it's not so much that the numbers are changing, but there's a fair amount of uncertainty around the numbers you see. But that's one reason for looking at where are the differences large and where are they small? If they're small, then maybe you don't want to spend too much time worry about them. But for some of the large ones -- it's hard to look at those for too long and not seeing that you're seeing some issues with the payment system that ought to be addressed.

With respect to non-allowables, you're not going to know more in the middle of January than you know now, other than to know that that issue is out there and to know the direction it goes. We don't know the exact size.

MS. BURKE: But, Murray, I think -- just following up on Ralph's point, I think certainly one of the sensitivities -- market basket is always complicated, but the redistribution issues are always hyper sensitive because there are invariably -- I mean, in a market basket everybody is sort of invariably treated similarly.

But in the case of the redistribution, there are clearly winners and losers, all of whom have these strange Congressional district realities. And urban/rural realities are, as you know as well as I do, quite dramatic. So a full understanding of that before we make a decision which we can certainly argue solely based on good analysis, I think we ought to still have the sense of that. It would be helpful to us.

DR. REISCHAUER: I was wondering if we had the margins for Medicare outpatient by hospital type geographic?

DR. WORZALA: You'll have that for January.

MR. KERNS: They're pretty much all the same, negative 17 across the board. But in '02, with the corridor payments, the rurals fall to negative 13. So they tend to do --

DR. REISCHAUER: I was wondering if they were all the same or --

MR. KERNS: They were all the same in '99, within a point of one another. But by 2002, with the corridor payments, the rurals do about four points better and the other groups don't move.

DR. NEWHOUSE: I think this has been our policy all along, but let me just reiterate. Our first job ought to be to present at least the empirical level. And if we think we ought to deviate it for some reason, we say so and say the reason.

Obviously, the Congress can always make the exceptions that it chooses to make, and presumably will do so. But I don't know that we need to try to stay ahead of the Congress in that respect.

MS. BURKE: No, and I wasn't supposing that. I was just suggesting that we ought not to go into that tunnel blindly and not understanding what the ramifications are. I'm not suggesting we base the analysis solely on what [inaudible].

MR. HACKBARTH: So the one reasonably concrete proposal that we've touched on is doing away with the urban/rural differential and potentially with the add-on of going to the empirical level on IME. So what I hear Ralph and Sheila, and perhaps others, asking for is exactly what does that mean? How much money is going to be transferred from whom to whom?

Is there any way that we can provide some information in advance of the January meeting? As opposed to getting it a day or two in advance of the meeting, give people a chance to chew on it a bit and perhaps ask a few more questions about it?

MR. ASHBY: I was wondering about the same question. If we were to redo the multivariate analysis oriented around the question of the appropriate base rate for the three groups, we most assuredly cannot do that by January. But we can probably summarize some of the results of our two-year-old analysis with and without the volume adjustment that may help the situation.

But we certainly can't redo the analysis in that amount of time. So we're going to have to go home and think about that one, I guess.

DR. ROSS: At the same time, on a number of these questions, paying the empirical level off for the indirect med ed payments, you already know what the impact of that is. You know who it's going to affect. We can give you a quantification, but we can probably even do that with a back of the envelope calculation, $2 billion on an X billion dollar base. But we already know who those hospitals are. We know where they are. And there's really only one more piece of information, and that's quantifying the percentage impact.

So we could talk about trying to get implications of these various steps, but we already know the implication of going to a single rate because we know who wins and who loses out of that. We know what happens on the empirical level. In some respects, the analytical part of it is not that complicated. The policy and political aspect of it is the difficulty.

MR. MULLER: People are much more willing to engage in -- hypothetically, if the margin is plus 10 percent, people are much more willing to engage in redistribution than if it was minus 10.

So if the overall was minus 10 -- because in part people think there's a "excess" to be redistributed. If everybody's kind of underwater, then they get less into redistribution. So therefore, the question of what the margin, in fact, is does influence people's willingness to consider it.

Secondly, the kind of categories that you use, I must say I'm not fully following the discussion on the major urban versus the other urban, exactly how you and Craig ultimately came out on that one. So I'll get briefed on that later.

But the categories that you use become important, too, which ones you use. So I'd like to get a little sense of how you chose the categories, where they come from.

So part of my point is that the magnitude of the numbers also start driving how one looks at them. And so therefore, it's important to see what they are and obviously the kind of distributional question becomes very key, as well.

Again, I'll go back to the SNF discussion, as well. Perhaps this business is a few hours old, it's not as much in our mind right now, but those numbers were much more enormous than the ones we're discussing in the hospitals. So I think as we think about what we want to do, we have to think about this, as you say, across the board and how we want to make this kind of adjustments.

MS. BURKE: There's also a timing issue. Joe's point is exactly right, that we shouldn't be adjusting things solely on the basis of what the political implications are, or at all. But there are decisions that you can make at the margin as to how quickly you get to what your optimum policy is. If you want to go to the empirical evidence and you want to go to the base number, and you want to go right now, that's one solution.

The other is to get there over a period of time. If there's a shift of $2 billion and you look at what the implications of that are, unrelated to the politics of it the reality is you may just not want to take people down that quickly. And so you have choices along the way.

I think in understanding what the implications are, I mean I know you can do a fairly quick calculation on that piece and know who the winners and losers are. The question for us, I think, should be in part how quickly do we want to move people to the policy and what's the disruptive effect of having done so over too short a period of time?

There's a perfect answer but there's not necessarily a perfect way to get there.

MR. ASHBY: Dovetailing on that very point, we went into this presentation that at best what we would consider doing this year would be a change to the base rates of maybe a half point or something, to begin moving us in the direction of one rate. And we were not really going to contemplate doing anything major with the IME subsidy because it's such a large issue, both analytically in terms of the number of dollars.

One of the things we might consider is just sort of saying let's take that issue and put it in the next cycle and for this very short amount of time we have focus on this more narrow base rate issue, which seems more viable in the short run.

MR. HACKBARTH: I agree with everything Murray said. We all know the directional effects and we can do our back of the envelope calculations. I still think it would be helpful though, Murray, if we could have in black and white a common description of this, including some options like do we do just the urban/rural differential? Or do we do that plus IME? And some of the options about pace of change.

We all have our own notions of what those variations are but we ought to have one set of options that we're working from. I think if we only have that when we walk in the door on January 16th, or whatever it is, it's going to make it a lot harder for us to get to a conclusion than if we have it reasonably well in advance of the meeting.

So personally, I'm not looking so much for new numbers to be crunched as for a frame to be put around some of these issues. Now not just the broad considerations, but here are policy options for the Commission to consider. And the sooner the better.

DR. ROWE: I think I'm basically going to say the same thing, I think, that I heard Jack say. I was looking at this sheet that was handed out earlier today. We were going to look at how they estimate it and how they're going to assess the appropriateness, and here are the six or eight factors.

And I think, with all due respect, Joe's suggestion of by the way, why don't we take this multi-billion subsidy that's paid through the IME payment and get rid of that as a kind of throw it on the table, is a broad discussion which I didn't see on what I expected to talk about. I'm not saying it's inappropriate for MedPAC, but I think it's -- the last time we talked about this it took a couple of minutes and there were a variety of opinions presented and material presented.

So I don't feel an urgency to deal with that issue immediately, unless Congress is expecting an updated opinion from us on that issue. And I would have thought that we would limit the decisions we make, and they're not trivial and they have a lot of major policy implications in them, to these other issues that we talked about, about distribution and et cetera.

MR. SMITH: I think I agree with what Jack just said, although I must say Craig seemed, to me, to put an additional issue on the table by reminding us that when you volume adjust a lot of the geographic differences go away, if I understood him correctly and remember that discussion from a year ago. If that's true, then it's not at all clear to me that the way to deal with the apparent empirical differential is to address it on a geographic metric.

I'd be very cautious, I think I end up where Jack does, although I'd be very cautious about taking steps which assume geographically is the right discriminator, fixing that, when we've got lurking in the background what may be a much more important observation about what accounts for cost differences. And how we would adjust that is not the same thing as how we get rid of a 1.6 map difference.

So if we know that, and if we're not obliged -- Sheila's point, if we're not obliged to do something dramatic that we don't quite know what it's consequences are, I'd put on the brakes a little bit and try to deal very modestly with decisions that don't take us beyond what we have a real empirical base for, instead of simply some symbols that represent numbers that may not tell us what we really want to know.

MR. HACKBARTH: Any other comments?

DR. REISCHAUER: We've come full circle.

MR. HACKBARTH: In what sense?

DR. REISCHAUER: I think what David is saying is you're backing off of even eliminating the rural adjustment.

MR. SMITH: If, Bob, we thought that eliminating the rural adjustment would get us to appropriate payments --

DR. REISCHAUER: A more appropriate payment.

MR. SMITH: But if what underlies the current distinct difference is volume, not geographically, maybe the rest of us understand what the consequences of addressing a volume issue through a geographic tool would be. I don't.

MR. HACKBARTH: Wouldn't that argument favor getting rid of the geographic based adjustment? If you feel the real issue is volume, you'd want to move as quickly as possible to a single base rate and then take up the question of whether we, in addition, need to do volume adjustment.

MR. SMITH: I guess I'm cautioned in that regard, Glenn, by the issue that several people have raised, you raised it at the beginning of this discussion, is we continue -- and I think appropriately, as difficult as it is. We continue to wonder what this Medicare margin means in the context of a different set of numbers rooted in a different set of realities for total margin.

We're constantly sort of -- we don't want to suggest that we're looking at total margin, but everybody around this table does. It would be foolish, it seems to me, to say that what we want to get to here is an empirical reality that may make the ability of hospitals operating under certain circumstances to provide appropriate care more difficult.

And maybe I'm slow and shouldn't have missed the November meeting, but I don't think we know enough to say at the moment the right thing to do is to embark on a path, however modulated as Sheila suggested, to get rid of that 1.6. I don't feel like I know enough to conclude that yes, let's go that far and then turn our attention to something else.

MR. HACKBARTH: We're not going to resolve that issue today. Based on the comments thus far, I think there's a significant division on that. So I want to avoid any implication that I'm trying to get you to implicitly endorse that right now. I'm not.

But we do need to make a decision come January and I'm much more concerned about how we prepare as well as possible for the discussion that needs to happen then. We may end up still divided and we'll have to deal with that.

But I'd like to see some of the issues made -- some of the options now. I think we've got to get beyond the issues to options. I'd like to see them made as concrete as possible and their implications as concrete as possible, so that people can start formulating their thinking well in advance of the January meeting.

DR. ROSS: Let me just add to that. If you go back to the table on page 12, you should take a look at that and we'll bring you back some options, we'll bring you back some analysis. But at the end of the day you're going to have to ask yourself when I look at that 3.8 overall Medicare margin, is that a number you're comfortable with? Because that's going to help guide your update decision. You're going to have to look at the nine point spread between hospitals in large urban areas and rural hospitals and say are you comfortable with that? And you're going to have to look at the 11 point spread between major teaching and non-teaching hospitals and way are you comfortable with that?

That's not to say you're going to have to resolve it on January 15th or 16th, whatever day we're meeting, but as laying out directions for future work. As staff, we do not want to push you beyond your comfort level. I appreciate it's hard enough having to make these multi-billion dollars decisions on the basis of three-year-old data trended forward.

But those are your decision points.

MR. MULLER: But the discussion you've had the last hour is what categories do you choose? If you look at your page 12, if you look at the middle column and you see a nine point spread between the large urban and rural. If you look at the third column, you have a 4.2 percent spread, a half a spread.

So part of what you see is that half that spread is driven by a DSH IME decision rather than urban/rural. So you start to ask yourself if more than half of that decision is driven by that, is that really the distinction to make?

I mean, you can cut the column by ethnicity. Some countries are driving out immigrants. So be very careful about what categories you use, because there may be other things driving that. I'm just cautioning you, as you start looking at this urban/rural, there's other things going on there besides just geography.

DR. ROSS: Absolutely. If you look at the appendix in the March report, we slice and dice by about every way you can. What distinguishes these categories, and maybe a couple of others, is they reflect deliberate policy decisions, unlike ethnicity and distance from Omaha, or whatever.

MR. HACKBARTH: I think that the presentation today and the materials that we got in advance very successful in terms of raising issues. Thank you for that.

But alas, that is not enough. I think the final decisions are going to depend, in part, on people's assessment about not just direction but how far, how fast, and that sort of stuff. It's going to take a while, for me at least, to get my arms around that.

So again, I would like to see some concrete options with restatements of their implications as far in advance as possible. And I'd personally rather have the staff spend their time doing that well than generating all sorts of new tables and numbers, because I think that's where the nitty-gritty is and the judgments about these things, not in pushing numbers around.

So we are now finished, for today at least, on payment adequacy. The next issue on the agenda is what's next for Medicare+Choice?